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**Written evidence submitted to the
Public Accounts Committee on Financial Sustainability of the NHS**

By

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Pete Murphy, Nottingham Trent University³**

1st January 2017

We welcome this opportunity to submit written evidence to the Public Accounts Committee on the Financial Sustainability of the National Health Service (NHS). This reply draws on recent published academic work, senior level personal experience of public service management and accounting practices, and response to the House of Lords Select Committee on Long-Term Sustainability of the NHS (Ferry and Gebreiter, 2016).

The National Audit Office (NAO) (2016a) has recently repeated its view that financial problems are endemic in the NHS and the situation is not sustainable, and that while there have been efforts to stabilise the system by the Department of Health, NHS England and NHS Improvement, they have not demonstrated balanced resources and value for money.

We concur with the view of the NAO on the current financial situation and so rather than repeat any of these messages the main focus of our response concerns whether the accountability arrangements for the sustainability of the NHS are ‘fit for purpose’. This is especially the case given ongoing resource pressures (Ham et al., 2015) and structural fragmentation (NAO, 2014, 2015a, 2016b, 2016c).

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The NHS has been subjected to reforms addressing its sustainability since its creation in 1948 (Ferry and Scarparo, 2015). In the 1950s, there were concerns regarding cost and performance. In the 1960s, concerns re-emerged around service efficiency and tripartite administrative arrangements effectiveness. In 1974, these concerns led to first major reorganisation of NHS. In the 1980s and 1990s, neo-liberal “New Public Management” reforms were introduced into the NHS by successive Conservative governments heralding an era of performance management to improve productivity and reduce waiting times. An internal market, market-driven incentives and management budgeting were introduced, despite resistance from the medical profession. The financial sustainability of the NHS remained an issue despite these reforms. The New Labour government from 1997 to 2010 therefore provided high levels of investment for the NHS, but surprisingly coupled this with more upheaval and further neo-liberal reforms. They extended the performance management agenda inherited from the outgoing Conservative government beyond financial numbers to encompass all aspects of managerial and organisational performance through a framework of hierarchical accountability and centralised control.

Following New Labour, the Conservative/Liberal coalition government from 2010 to 2015 largely maintained accountability and transparency arrangements for financial conformance and operational performance in the NHS, but the structural and operational framework of hierarchical control was dramatically altered with significant consequences (Ferry and Murphy, 2015). This was due to significant changes from the Health and Social Care Act 2012, the Local Audit and Accountability Act 2014 and other initiatives such as quality accounts, all of which were implemented at a time of financial restraint. These changes resulted in the fragmentation of services, which dramatically obscured overall accountability and undermined the ability to determine if value for money was being accomplished and thus posed risks for financial sustainability (Ferry and Murphy, 2015). In particular, these changes meant that the healthcare system as a whole, and individual organisations and services within it, increasingly struggled to meet centrally set objectives and targets, most notably Acute Hospitals Trusts (NAO, 2014, 2015b).

On the other side of the coin, NHS finances were under pressure for various reasons. The NHS budget was relatively protected compared to other public services, but it is arguable whether, in real terms, this was sufficient. Systemic risks from cuts in local government budgets that affected adult care especially meant that costs were pushed onto the NHS, with

more elderly people who could have been looked after in the community ending up in hospital. Attempts to link the NHS and local government budgets and services will take time to bed down to see if they are successful, but given current financial issues these arrangements may not be afforded the necessary time. This position is also arguably further complicated by the legacy of financial and service issues of New Labour such as servicing PFI debt interest, favourable changes to staff terms and conditions, and fallout from healthcare scandals that continue to have cost implications. In addition, unlike local government that has a statutory requirement to set a balanced budget (Ferry, Eckersley and Zakaria, 2015), there is no such statutory imperative in the NHS, and thus a systemic risk of financial failure is prevalent as services may be continued beyond budget confines.

Given these issues, it is important to consider how accountability and transparency can be extended beyond traditional hierarchical accountability structures of a NHS based on a public service delivery model. This is so that new, hybridised and distributed forms of delivery involving various forms of arms-length bodies, commercialisation and privatisation can be properly and appropriately held to account (Ferry and Murphy, 2015).

Within the context of this history, it is argued that although the marketization of healthcare and governance through performance management have enjoyed some successes in maintaining services, they cannot discipline and control health services and associated costs to solve the myriad of long-term problems facing healthcare sustainability in the 21st century (Ferry and Scarparo, 2015).

Having said that, it is arguable that concerns around cost of health care are historically contingent rather than inescapable consequences of demographic and technological change. For example, Gebreiter and Ferry (2016) examined emergence of concerns for health expenditure in wake of creation of British NHS in 1948, and their relationship with health service accounting practices. They suggested that the nationalization of health services, together with the initial compilation of health estimates and changing notions of health and disease, constituted the cost of health care as an insoluble problem in mid-20th century. Health care became discussed as a cost rather than as an investment in the productive capacity of citizens which would promote economic growth. They also showed that health service accounting practices are both constitutive as well as reflective of concerns regarding the cost of healthcare, and that these relations did not only begin with the New Public

Management reforms in 1980s as widely believed. In addition, they cautioned that current reforms promoting decentralization of health services in Britain and beyond (e.g., Prime Minister's Office, 2011) could reduce rather than increase accounting's ability to facilitate control of health service costs. Finally, they argued both in 1950s and at present, concerns regarding ageing populations, expensive medical technologies and cost of health care have focused much attention on accounting practices that seek to encourage hospitals to provide various health services at lowest possible cost (i.e., maximize their technical efficiency). Conversely, questions as to whether hospitals use the most efficient mix of inputs to provide these services (i.e., maximize the allocative efficiency of health service inputs), and whether hospitals produce those services which provide greatest health benefits relative to their costs (i.e., maximize the allocative efficiency of health service outputs), have attracted less attention. Indeed amidst emerging suggestions that health systems like the NHS cannot remain financially viable unless they focus scarce resources on those services that provide the greatest health benefits relative to their costs (e.g., Health Foundation, 2015), there needs to be more engagement with the issue of allocative efficiency in health services.

In addition, consideration should be given to the broader monitoring regime. Lord Kerslake has floated the idea of introducing a statutory requirement for balanced revenue budgets in the NHS that exists for local government (Ferry, Coombs and Eckersley, 2017). The budget regime could however go further, beyond merely adherence to budget conformance and/or service performance and take account of risks concerning governance arrangements and cultural specificities when considering sustainability (Ferry and Murphy, 2015). Interestingly, this was also highlighted recently as a concern in local government (Ahrens and Ferry, 2015, 2016; Communities and Local Government Select Committee, 2016; Ferry, Coombs and Eckersley, 2017).

Furthermore, often the NHS is politically construed as a '*national treasure*' that is sacrosanct and somehow more protected relative to other public services. The protection afforded in recent budget rounds relative to say local government is evidence of this (Ferry, Eckersley and Zakaria, 2015). However while it may or may not be justifiable to prioritise the NHS, it is important that it is not seen as an isolated and/or untouchable body.

The NHS must be viewed as part of broader health and social services that encapsulates other parts of the 'welfare state' including adult care, employment, housing and welfare, all of

which may have preventative features. Also it seems important to reconsider these preventative features as investments and not merely as costs. Indeed there is an increasingly strongly held view and arguably evidence that prevention or protection services in public health as in other public services are being disproportionately hit by financial cuts when compared to reactive services. It is a bit of a cliché but are we are treating symptoms rather than causes. Thus storing problems and greater per capita costs up for the future.

The accountability and transparency arrangements of the NHS (Commons Select Committee, 2013), its financial sustainability (NAO, 2014, 2016) and the design of public services more generally (Lord Bichard, 2011) therefore requires a broad and fundamental rethink extending to the foundations of the welfare state itself in order to protect this most valuable ideal for both current and future generations.

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